





Physician Billing Department

STATEMENT OF PHYSICIAN BILLING DEPARTMENT

<input type="checkbox"/> VISA	<input type="checkbox"/> MASTERCARD	<input type="checkbox"/> DISCOVER	<input type="checkbox"/> AMERICAN EXPRESS	<input type="checkbox"/> DINERS CLUB
CHARGE \$		TO CREDIT CARD #		
SIGNATURE:		EXP DATE:		
STATEMENT DATE	DUE DATE	AMOUNT YOU OWE	AMOUNT ENCLOSED	
09/29/07	10/14/07	\$4448.14	\$	

QUESTIONS? CALL YOUR ACCOUNT SPECIALIST, LORRAINE GORDON,  
AT 646-227-3154, 8:30AM-4:00PM. CALLERS OUTSIDE  
AREA CODES 212/646/718 SHOULD CALL 800-999-3275.

HELEN S KAHANER  
20 HARROGATE DRIVE  
HILTON HEAD ISL, SC 29928

MAIL PAYMENT TO:

PHYSICIAN BILLING DEPARTMENT  
PO BOX 26352  
NEW YORK, NY 10087-6352

☐ PLEASE CHECK THIS BOX IF YOUR ADDRESS OR INSURANCE HAS  
CHANGED AND MAKE YOUR CHANGES ON THE REVERSE SIDE.

PLEASE DETACH TOP PORTION AND RETURN WITH YOUR PAYMENT

## STATEMENT OF PHYSICIAN SERVICES

(STATEMENT DATE: SEPTEMBER 29, 2007)

MEDICAL RECORD # 35156600  
PATIENT NAME: HELEN S KAHANER

QUESTIONS? CALL YOUR ACCOUNT SPECIALIST, LORRAINE GORDON,  
AT 646-227-3154, 8:30AM-4:00PM. CALLERS OUTSIDE  
AREA CODES 212/646/718 SHOULD CALL 800-999-3275.

THE FOLLOWING INVOICES DESCRIBE OUTSTANDING CHARGES FOR SERVICES RENDERED BY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS  
AT MEMORIAL SLOAN-KETTERING CANCER CENTER. THE LEFT SIDE DESCRIBES THE SERVICES PROVIDED. THE RIGHT SIDE DESCRIBES INSURANCE  
CLAIMS AND PAYMENTS.

INVOICE NUMBER: 13103689

PROVIDER: ROBERT T HEELAN MD  
RADIOLOGY GROUP

03/09/07 CHEST SINGLE VIEW FRONTAL. .... \$45.00  
TOTAL CHARGES: \$45.00

### PAYMENT ACTIVITY

03/09/07 TOTAL CHARGES \$45.00  
03/14/07 INSURANCE CLAIM FILED  
08/15/07 PAYMENT PRIMARY INSURANCE. .... -28.35  
AMOUNT YOU OWE. .... \$16.65

INVOICE NUMBER: 13131689

### CHARGES

PROVIDER: SAMSON W FINE MD  
PATHOLOGY GROUP

03/09/07 LEVEL V-GROSS AND MICROSCOPIC EXAM ..... \$300.00  
03/09/07 LEVEL V-GROSS AND MICROSCOPIC EXAM ..... \$300.00  
03/09/07 DECALCIFICATION PROCEDURE ..... \$20.00  
03/09/07 LEVEL IV-GROSS AND MICROSCOPIC EXAM 5 UNIT[S] ..... \$750.00  
TOTAL CHARGES: \$1370.00

### PAYMENT ACTIVITY

03/09/07 TOTAL CHARGES \$1370.00  
03/22/07 INSURANCE CLAIM FILED  
08/09/07 PAYMENT PRIMARY INSURANCE. .... -863.10  
AMOUNT YOU OWE. .... \$506.90

INVOICE NUMBER: 13220113

### CHARGES

PROVIDER: HARRY W HERR MD  
UROLOGY GROUP

03/09/07 NEPHRECTOMY, PARTIAL ..... \$11865.00  
03/09/07 ULTRASOUND, INTRAOPERATIVE ..... \$500.00  
TOTAL CHARGES: \$12365.00

### PAYMENT ACTIVITY

03/09/07 TOTAL CHARGES \$12365.00  
04/23/07 INSURANCE CLAIM FILED  
08/09/07 PAYMENT PRIMARY INSURANCE. .... -8739.41  
AMOUNT YOU OWE. .... \$3625.59

CONTINUED ON REVERSE SIDE ...

PATIENT NAME **Case 1:07-cv-09626-NRB Document 23-2 Filed 05/16/2008 Page 3 of 3**

STREET ADDRESS, APT #

CITY STATE / PROVINCE POSTAL CODE COUNTRY

EMPLOYER

LOYER STREET ADDRESS CITY STATE ZIP CODE

INSURANCE CHANGES

INSURANCE COMPANY ☐ CHECK BOX IF HMO

SUBSCRIBER'S NAME SUBSCRIBER'S DATE OF BIRTH

I.D. NUMBER GROUP/PLAN NUMBER EFFECTIVE DATE

MAILING ADDRESS FOR CLAIMS

CITY STATE ZIP CODE

\*\*\* IF POSSIBLE, PLEASE ENCLOSE A COPY OF YOUR INSURANCE ID CARD (FRONT AND BACK) WITH THIS CHANGE \*\*\*

## STATEMENT OF PHYSICIAN SERVICES

(STATEMENT DATE: SEPTEMBER 29, 2007)

G4

MEDICAL RECORD # 35156600  
PATIENT NAME: HELEN S KAHANER

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### CHARGES

INVOICE NUMBER: 13243203

PROVIDER: PAUL H DALECKI MD  
ANESTHESIOLOGY GROUP

09/07 KIDNEY, URETER SURG  
235 MINUTES..... \$2990.00  
TOTAL CHARGES: \$2990.00

### PAYMENT ACTIVITY

03/09/07 TOTAL CHARGES \$2990.00  
04/30/07 INSURANCE CLAIM FILED  
08/09/07 PAYMENT PRIMARY INSURANCE..... -2691.00  
AMOUNT YOU OWE..... \$299.00

YOUR LAST PAYMENT OF \$141.75 WAS RECEIVED ON 05/03/07.

ACCOUNT BALANCE	AMOUNT PENDING WITH INSURANCE	KINDLY REMIT IN FULL BY 10/14/07
\$4448.14	\$0.00	\$4448.14